AUTHORIZATION / REQUEST FOR PATERNITY BLOOD TEST

State Form 7859 (R3 / 3-96) / FM 0435

Mail this Form to:

Financial Management
Family and Social Services Administration
402 W. Washington St. P.O. Box 7128
Indianapolis, IN 46207-7128

INSTRUCTIONS: To be completed and signed by Prosecuting Attorney and forwarded, with Child Support Bureau approval for payment, to provider named below. Claim--Voucher (reverse) to be submitted by provider for payment to address listed above.

This state agency is requesting disclosure of your Social Security number in order to expedite processing of this form. Disclosure is voluntary and you will not be penalized for failure to do so per IC 4-1-8. Records in this series are **CONFIDENTIAL** per IC 12-1-6.1-15.

County of Prosecuting Attorney

Name of medical services provider

Street address

City, state and ZIP code

Indiana IV-D Case number

AUTHORIZATION NOT VALID WITHOUT CASE NUMBER

Indiana Welfare Case number (ICES)

REQUESTED SERVICES

☐ Perform red cell antigen test ☐ Perform HLA test ☐ Draw blood samples ☐ Other *(specify)*

☐ Ship blood samples to: *(name)*

Street address

City, state and ZIP code

You are requested to provide the above indicated medical services for the individuals listed below to assist in the determination of paternity for the child named.

INDIVIDUALS FOR WHOM PAYMENT HAS BEEN AUTHORIZED

Name of child's mother	Social Security number
Name of child	Social Security number
Name of child	Social Security number
Name of putative father	Social Security number
Name of putative father	Social Security number

Comments

Upon completion of the services requested, you are hereby authorized to submit billing to the Indiana Family and Social Services Administration, Division of Family and Children, Child Support Bureau for these services.

CERTIFICATION

I certify that I am the duly authorized agent of the Indiana Family and Social Services Administration, Division of Family and Children, Child Support Bureau in IV-D paternity matters in this jurisdiction. I further certify that these services have been requested pursuant to a court order or an agreement between the parties in a IV-D paternity case, and these services are necessary to carry out my obligation pursuant to the terms of a cooperative agreement between this jurisdiction and the Indiana Family and Social Services Administration, Division of Family and Children, Child Support Bureau.

Signature of authorized agent	Title	Date signed *(mo., day, yr.)*

CLAIM -- VOUCHER

State Form 11294 (R3/5-89)
Approved by State Board of Accounts 1989

INSTRUCTIONS: This agency is requesting disclosure of your Social Security number in accordance with IC 4-1-8.

VENDOR INFORMATION		AGENCY INFORMATION
Document number	Date *(month, day, year)*	Agency name **Division of Family and Children, FSSA**
Vendor name		Agency number **500**
Address *(number, street)*		Social Security number or
		Federal I.D. number
City, State and ZIP code		Vendor number

AREA BELOW TO BE COMPLETED BY AGENCY

DATE		AMOUNT	FUND	OBJECT	CENTER	LOAN / INV / NBR	QTY	UNIT	DESCRIPTION
			3510	**573600**	**150000**				**MH**
									Type of test
									Mother
									Child
									Child
									Putative father
									Putative Father
									Case number
									Prepared by:
									Invoice number
									Telephone number ( )
									Date *(month, day, year)*

GROSS AMOUNT: $	Furnished to: *(name of state agency)* **Division of Family and Children, FSSA**

I certify that this claim is correct and valid and is a proper charge against the State Agency, Fund and Center indicated.

Authorized signature of state agency	Date signed *(month, day, year)*

Pursuant to the provisions and penalties of IC 5-11-10-1, I hereby certify that the foregoing Fund and Center is just and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid.

Signature of vendor	Date signed *(month, day, year)*